GUIDE TO LONG-TERM CARE

This guide has been prepared by the Wisconsin Office of the Commissioner of Insurance and must be given to all prospective buyers of long-term care insurance at the time an application is taken or when long-term care insurance is solicited, whether or not the solicitation results in a sale.

For information on how to file an insurance complaint call:

Insurance Complaint Hotline
1-800-236-8517 (Statewide)
or
(608) 266-0103 (Madison)

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS

For more information on long-term care insurance call:
Medigap Helpline
1-800-242-1060

The Medigap Helpline is a statewide toll-free number set up by the Wisconsin Board on Aging and Long-Term Care to answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

State of Wisconsin
Office of the Commissioner of Insurance
P. O. Box 7873
Madison, Wisconsin 53707-7873

OCI's World Wide Web Home Page:
http://oci.wi.gov

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ATTENTION

A list of long-term care insurance policies currently being sold in Wisconsin may be obtained from:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, Wisconsin 53707-7873

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, please contact the Office of the Commissioner of Insurance at the address given above or call 1-800-236-8517. Deaf, hearing, or speech impaired callers may reach OCI through WI TRS.

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the Commissioner of Insurance . . .

Leading the way in

informing and protecting

the public

and

responding to their

insurance needs.

This guide is not a legal analysis of your rights under any insurance policy or government program. Your insurance policy, program rules, Wisconsin law, federal law and court decisions establish your rights. You may want to consult an attorney for legal guidance about your specific rights.

The Office of the Commissioner of Insurance (OCI) does not represent that the information is complete, accurate or timely in all instances. All information is subject to change on a regular basis, without notice.

Printed copies of publications are updated annually unless otherwise stated. In an effort to provide more current information, publications available on OCI's Web site are updated more frequently than the hardcopy versions to reflect any necessary changes. Visit OCI's Web site at http://oci.wi.gov.

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Frequently Asked Questions

Does Medicare cover long-term care services?

Medicare provides only limited coverage for long-term care related primarily to recuperating from a sickness or injury. Medicare pays only for skilled nursing care and medically necessary services. You should not rely on Medicare to pay for your long-term care needs.

Can my premiums be increased?

Yes, premiums for all long-term care insurance policies may be increased. However, if premiums are based on issue age, they may only increase if premiums are increased for all individuals insured under the same type of policy. If premiums are based on attained age, premiums will increase as you age.

Can the insurance company cancel my long-term care policy?

No, your policy is guaranteed renewable for life. The policy may terminate only when you cease paying your insurance premiums or if you use the maximum amount of benefits available under the policy.

Are preexisting conditions covered under long-term care insurance policies?

Preexisting conditions must be covered by long-term care insurance policies. However, insurance companies may have a preexisting condition waiting period of up to six months. After your policy is in effect for six months, it will pay for covered benefits.

Are Alzheimer's and other dementias covered by long-term care insurance?

Alzheimer's disease and other dementias are required to be covered by long-term care policies. However, if you have Alzheimer's or other dementia at the time you apply for coverage, the insurance company is not required to accept your application or to issue coverage.

What is an elimination period?

An elimination period is similar to a deductible. This means that when you begin using long-term care services, there is a waiting period before the policy begins paying benefits. You are responsible for paying for all expenses during the elimination period.

Are benefits paid for all institutional settings, such as community based residential facilities (CBRFs), assisted living facilities, and residential care facilities?

Long-term care policies pay only those benefits described or defined in the policy. Some policies pay for assisted living facilities, some do not. Most policies do not cover CBRFs or other placement. Read the definitions in your policy carefully.

How much does a stay in a nursing home cost?

The costs of nursing home care vary among facilities and locations. You should contact those facilities that you would consider acceptable and ask about their current daily charges. You can then determine the amount of coverage you will need.

What is Long-Term Care?

In general, the phrase "long-term care" refers to a broad range of services you may need for an extended period of time because of a chronic illness or disability. It usually does not include the type of care you receive on a short-term basis following a hospitalization or an acute illness.

Long-term care includes medical services, such as nursing care or therapies. It also includes supportive services, such as help in bathing, dressing, getting in and out of bed, taking medicines, or preparing meals. Long-term care can be provided in a variety of settings, including nursing homes, your home, an adult day care center, or a group living arrangement with supportive services. Community-based long-term care (provided outside of nursing homes) is often given by family and friends, but can also be provided by paid individuals or agencies, some of which are licensed by the state and/or certified by public funding programs like Medicare.

Nursing Home Care

Care in a nursing home includes several different levels of care:

Skilled Nursing Care

This is care furnished on a physician's order that requires the skills of professional personnel, such as a registered nurse or a licensed practical nurse, and is provided either directly by or under the supervision of these personnel.

Intermediate Nursing Care

This is basic care including physical, emotional, social, and other restorative services given under periodic medical supervision. This nursing care requires the skill of a registered nurse in administration, including observation and recording of reactions and symptoms, and supervision of nursing care.

Personal or Custodial Care

This is care that can be performed by persons without medical training and that is primarily for the purpose of meeting the personal needs of the patient, including feeding and personal hygiene.

Community Based Long-Term Care

Community-based long-term care can be provided in many settings and by many kinds of providers. If you are receiving several services from different providers, a professional case manager may be involved in arranging for and managing the services. A few of the specific kinds of services and agencies that provide community-based long-term care are:

Home Health Care

Home health care includes:

- Skilled nursing services, such as providing therapy treatments or administering medication;

- Home health aide services, such as checking temperature and blood pressure;
- Personal care, such as help with bathing, dressing, walking, exercise; and
- Physical, occupational, respiratory, or speech therapy.

Assisted Living Facility

Assisted living facility care is care given in a residential facility and includes supportive, personal, or nursing services. Supportive services may involve assistance with meals, housekeeping, laundry, and arranging for transportation. Personal services means direct, hands-on help with activities of daily living.

Adult Day Care

Adult day care is care given in a nonresidential, community-based group program designed to meet the needs of functionally impaired adults. It is a structured, comprehensive program that may provide a variety of health, social, and related support services during any part of a day.

Respite Care

Respite care is the provision of personal care, supervision, or other services to a functionally impaired person in order to temporarily relieve a family member or other primary caregiver from caregiving duties. Respite care services are usually provided in the impaired person's home or in another home or homelike setting, but may also be provided in a nursing home.

Hospice Care

Hospice care is a specially designed package of social and medical services that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families.

Who Needs Long-Term Care?

Whether you require long-term care depends on your level of disability. The chances of needing long-term care usually increase as you age, but long-term care may be needed at any age.

It is important to recognize that at some time in your life you may require long-term care services. Therefore, you should think about how to pay for this care.

In Wisconsin in 2001, 5% of all people age 65 and over resided in a nursing home. That number increased to 20% for persons above age 85.*

The longer a person lives, the more likely it is that he or she will need some kind of long-term care. Some people who have acute illnesses may need nursing home or home health care for only short

* Wisconsin Department of Health and Family Services

periods. Others may need care for many months or years. Many people who need long-term care receive that care in their own homes through services provided by home health agencies, relatives, or friends. Others receive care through nursing homes, group homes, or assisted living facilities.

How Much Does Long-Term Care Cost?

The costs for long-term care vary depending on the service. For example, in 2001, the average cost for a day in a nursing home in Wisconsin was approximately $132*. Home health care can also be costly. A home health visit by a registered nurse can cost approximately $100, depending on the length of the visit. Home health aide personal care services provided by a home health agency can cost $50 to $60 per hour.

Other types of long-term care services can also be expensive if they are provided frequently or for a long period of time.

Who Pays for Long-Term Care?

Private Individuals

Most long-term care is paid for by the people receiving the care or by their families. Other sources of payment include Medicaid (Medical Assistance), Medicare, veterans' payments, and private insurance. Many individuals who require extensive long-term care eventually "spend-down" their savings and other resources and become eligible for Medicaid.

Medicare

Medicare is the federal program that helps pay hospital and medical costs for those who are 65 or older and some disabled persons. **It provides very limited coverage for short periods of time for nursing home and home health care but does not cover any long-term care services for extended periods of time.**

Nursing Home Care

If a nursing home stay is approved by Medicare, then Medicare pays in full for up to 20 days of skilled nursing care in a skilled nursing facility approved by Medicare. However, Medicare will pay for your stay only if it follows a hospitalization of at least three days and you enter a Medicare-certified nursing home within 30 days after hospital discharge. From the 21st to the 100th day, Medicare pays part of the cost if the stay is still approved by Medicare. Medicare pays **nothing** beyond the 100th day. **Very few nursing home stays are covered by Medicare.** This is both because many nursing homes do not participate in the Medicare program and because Medicare defines "skilled care" in a very restrictive way.

* Wisconsin Department of Health and Family Services

Home Health Care

Medicare covers only those home health care visits **that Medicare considers to be medically necessary.** Medically necessary care is defined quite narrowly and you must meet certain other criteria before Medicare will pay for the care. For example:

- The care must include part-time skilled nursing care, physical therapy, or speech therapy;
- You must be **confined** to home;
- Your doctor must set up a home health plan; and
- The agency providing services must participate in Medicare.

Many home health care visits do not meet Medicare's definition of medically necessary care. Therefore, Medicare will not pay for them.

Medicaid

Medicaid, also known as Medical Assistance or Title XIX, is a government health care program paid for by state and federal governments. To be eligible for Medicaid:

- You must be 65 or over, or disabled, or in a family with dependent children;

  and

- You must have low income and few assets; or
- You must be paying so much money for health care that you have very little income left.

If you are eligible, Medicaid will pay for most health care costs, including nursing home and community-based care.

Nursing Home Care

Medicaid is a major source of payment for nursing home care. About 74% of all nursing home residents in Wisconsin receive help with their nursing home costs. To qualify for Medicaid nursing home benefits, you must require medical, nursing, and/or therapeutic care on a daily basis, and be under a doctor's plan of treatment. Even if you become eligible for Medicaid, most of your income must be used to pay nursing home bills, with Medicaid paying remaining costs.*

When first admitted, many residents of nursing homes are able to pay for their care themselves. Over the course of a long nursing home stay, many people use most of their savings to pay for their care and then become eligible for Medicaid.

* Wisconsin Department of Health and Family Services

Home Health Care

Medicaid may pay for services you receive in your home. However, you must be under a doctor's plan of care, have medical needs that can be met in your own home, and receive services from a home health care agency certified by Medicaid.

Personal Care

Medicaid also pays for personal care, such as assistance with bathing, dressing, eating, or getting in and out of bed. To be paid by Medicaid, you must be under a doctor's plan of care **and** you must receive services from a personal care agency certified by Medicaid. You may also be eligible for a limited amount of necessary household help such as grocery shopping, meal preparation, or laundry.

Community Options Program

In Wisconsin, the Community Options Program (COP) provides community-based long-term care services to some individuals who would otherwise need nursing home care. If you qualify based on limited income and assets, all or part of the cost of the care can be paid by a special state funding program or, in some cases, Medicaid. The COP offers a wide range of services including personal care, respite care, adult day care, transportation, and even necessary help with household chores. Information on eligibility for the COP may be obtained from your local county aging unit or your local county social or human services department.

SPOUSAL IMPOVERISHMENT PROTECTIONS

If you are married and have a spouse who is receiving long-term care in a nursing home, the law permits you to keep a certain amount of monthly income and retain a certain amount of assets even if your spouse's long-term care costs are being paid by Medicaid. The amount you are allowed to retain is in addition to the family home and other noncounted assets. You may obtain more information on-line at http://www.dhfs.state.wi.us/Medicaid1/recpubs/factsheets/spousimp.htm or by contacting your local county aging unit or your local county social or human services department and tribal agencies.

You may want to consider consulting with your local county aging unit or an elder law attorney if you are considering a "Medicaid-friendly" annuity to qualify for Medicaid.

Estate Recovery Program

Wisconsin has an estate recovery program through which the state seeks repayment of Medicaid payments for care received while the recipient resided in a nursing home. The program also seeks

recovery of certain noninstitutional Medicaid benefits for recipients over age 55. The recovery is made from the estate of a recipient or the estate of the recipient's spouse. An estate includes all assets owned by an individual at the time of death.

More information about the Estate Recovery Program is available from your local county social or human services department and tribal agencies.

Medicare Supplement Insurance

Medicare supplement insurance policies do not provide coverage for long-term care. They are designed to supplement Medicare and provide very limited coverage for nursing home and home health care.

For more information on the benefits included in Medicare supplement insurance policies, consult the booklet *Wisconsin Guide to Health Insurance for People with Medicare* which is available from the Office of the Commissioner of Insurance.

Types of Long-Term Care Insurance Policies

There are three types of insurance policies currently on the market in Wisconsin to cover long-term care expenses. They are:

1. **Long-Term Care Insurance Policies**

   These policies cover both institutional (nursing home or other facility) care and care in the community (home health care or other community-based services).

2. **Nursing Home Insurance Policies**

   These policies cover **only** institutional (nursing home or other facility) care.

3. **Home Health Care Insurance Policies**

   These policies cover **only** care received in the community (home health care or other community-based services).

NOTE

ONLY THOSE POLICIES THAT PROVIDE COVERAGE FOR BOTH INSTITUTIONAL AND COMMUNITY-BASED CARE MAY BE ADVERTISED OR SOLD AS LONG-TERM CARE INSURANCE POLICIES.

Wisconsin Minimum Standards for Policies

The Wisconsin Office of the Commissioner of Insurance has set minimum standards for each of the three types of policies covering long-term care expenses.

All three types of policies must:

- Provide at least one year of benefits.
- Provide a minimum $60 a day benefit.
- Provide benefits based on the level of care only if the lowest limit of daily benefits is not less than 50% of the highest limit of daily benefits. For example, benefits provided for home health care would have to be at least 50% of those provided for nursing home care.
- Provide coverage whether or not care is medically necessary. The policy may require that the care be provided in accordance with a plan of care.
- Pay benefits without requiring you to be in a hospital before getting the covered service.
- Pay benefits if you are unable to perform three or more activities of daily living (ADLs) or if you have a cognitive impairment. The assessment of ADLs and cognitive impairment needs to be performed by licensed or certified professionals, such as physicians, nurses, or social workers.
- Pay benefits for “irreversible dementia” (Alzheimer’s disease) provided you have met the waiting periods under the policy and need the type of care covered by the policy. This does not prevent an insurance company from refusing to accept an application from you if you have Alzheimer’s or a similar disease.
- Offer an inflation protection option that increases the maximum daily benefit and lifetime benefit amounts in an amount at least equal to 5% compounded annually.
- Offer a nonforfeiture benefits option that provides paid-up insurance if your policy lapses.
- Describe the benefit appeal procedure. This procedure requires the insurance company to review the appeal and make a decision within 30 days.

Policies that include home health care benefits must pay for community-based (home health) care:

- Whether or not you have an acute medical problem.
- Even if the services are not provided by a Medicare-certified agency or provider.
- Even if you were not previously in a hospital or nursing home.

NOTE

Policies that cover only nursing home care or only home health care provide limited benefits for long-term care services and may not be adequate for your needs. If you want coverage for both nursing home and home health care, you are better off buying a comprehensive long-term care insurance policy. Even a comprehensive policy may not cover all the types of services that you may need or want.

Federally Tax-Qualified Long-Term Care Insurance Policies

Congress passed a law in 1996 called the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows for certain federal income tax advantages for long-term care insurance policies that are designated as "tax-qualified" or "qualified." If you have a tax-qualified policy, you may be able to deduct part or all of the premium you pay for the policy. You can include the premiums with other annual uncompensated medical expenses in excess of 7.5% of your adjusted gross income. The amount of the premium that you can claim as a deduction depends upon your age.

Long-term care insurance policies sold on or after January 1, 1997, as tax-qualified policies must meet certain standards. These policies must contain a caption on the face page of the policy, similar to:

> **This policy is intended to be a tax-qualified long-term care insurance contract under Section 7702B (b) of the Internal Revenue Code.**

At the time you apply for long-term care insurance, you must receive an Outline of Coverage that contains a notice on the face page that indicates the policy is intended to be a tax-qualified policy.

Tax-qualified long-term care insurance policies are required to cover services for a chronically ill individual. These services are given according to a plan of care prescribed by a licensed health care practitioner. You are considered chronically ill if you are unable to perform a certain number of activities of daily living without substantial help from another person for at least 90 days. You also may be considered chronically ill if you need substantial supervision to protect your health and safety because you have a cognitive impairment.

The benefits paid by a tax-qualified long-term care insurance policy are generally not taxable as income. Benefits you receive from a nontax-qualified long-term care insurance policy may or may not be taxable as income. The U.S. Department of the Treasury has not yet ruled on this issue.

State Income Tax Deduction

Beginning in the January 1998 taxable year, you can subtract the amount paid for long-term care insurance from your Wisconsin income tax. This subtraction applies to both policies designated for federal income tax purposes as tax-qualified and policies that are nontax-qualified. The instruction booklet you receive with your Wisconsin income tax forms includes information on the subtraction for long-term care insurance.

Life Insurance - Long-Term Care Policies

Another way to cover long-term care expenses is through a rider attached to a life insurance policy. Long-term care riders attached to life insurance policies are different from long-term care policies in several respects. For example, monthly benefits for a stay in a covered nursing home are typically based on a percentage of the life insurance amount. A $100,000 policy with a 2% benefit would give you $2,000 a month. A monthly benefit for home health care, when covered under the rider, is usually half of the nursing home benefit.

Long-term care benefits under these riders are tied directly to the amount of life insurance in force. These benefits will be reduced by any loans or withdrawals against the policy. Using the long-term care benefits will also reduce life insurance coverage under the policy.

A long-term care rider has a separate insurance charge that usually increases each year in a manner similar to the cost of the life insurance under the basic policy. The annual charge for the rider will not exceed the guaranteed cost and will normally be less.

Should I Buy Long-Term Care Insurance?

Many people are interested in long-term care insurance to help pay for a stay in a nursing home or other long-term care services. However, long-term care insurance is not for everyone. For some individuals, long-term care insurance is an affordable and attractive form of insurance. For others, the cost is too high and the benefits are insufficient. The purchase of long-term care insurance should not cause a financial hardship by making you neglect other more pressing financial needs. Each person must examine his or her needs and resources to decide whether long-term care insurance is appropriate.

Whether you should buy a policy will depend on your age, financial status (including your assets and annual income), health, marital status, and overall retirement objectives. For example, if your only source of income is a minimum Social Security benefit or Supplemental Security Income (SSI), or if your assets and income make you close to Medicaid eligibility, you should carefully consider whether you can afford a long-term care, nursing home, or home health care policy. It makes no sense to buy a policy if you can’t afford to pay the premiums year after year.

Remember, if you have existing health problems that are likely to result in the need for long-term care, such as Alzheimer’s disease, you probably will not qualify for a policy.

What Should I Look for in Comparing Policies?

Type of Coverage

You should review how the policy pays benefits as policies pay benefits in different ways. For example, some policies pay a fixed amount for each day you are confined in a nursing home or each day you receive community-based care, regardless of the actual cost of the care. Other policies pay according to the provider's actual charges up to a fixed daily amount or a percent of the charges. Policies paying benefits based on a usual and customary charge basis or prevailing charge basis contain a notice to this effect on the face page of the policy.

You should also examine the period of time benefits are paid. Benefits may last for only one year or for the rest of your life, depending on the policy. In general, plans that provide payments for longer periods of time are more expensive. You may select from several options when you first buy the policy. You may not be able to increase the benefit amounts at a later date without proving insurability.

You should compare similar policies. For instance, compare nursing home only policies to nursing home only policies.

Policies frequently limit benefits to specific types of services provided by specific types of facilities or agencies. For example, services provided in the home may be limited to those provided by a licensed home health agency. Other types of personal care, help with household chores, or other services may not be covered. One policy may cover ambulance service to and from the hospital, but the same type of policy offered by another company may not. In other words, it is important to check each policy to be sure you know exactly what services are covered. The kind of long-term care services you may need or want may not be covered under the policy.

You should review the policy's definitions regarding the types of facilities that are covered. The state of Wisconsin has licensed, certified and registered facilities that provide differing levels of supportive care, personal care, and nursing services. Policies that provide coverage for nursing care in a licensed facility will cover care in a nursing home. However, the policies that provide coverage for nursing care in a licensed facility will not cover care in an assisted living facility. Assisted living facilities are certified or registered to provide assisted living services. They are not licensed to provide nursing care. Long-term care policies usually do not cover any care in a community-based residential facility.

You should determine whether premium payments are based on **issue age** or **attained age**. Attained age premiums automatically increase as one ages. Issue age premiums will increase only if premiums are increased for everyone insured under the policy form.

You should compare prices when you compare policies. Ask questions. Check to see if the policy you are considering is a lot less or a lot more expensive than other policies with similar benefits.

Standards for Benefit Triggers

Policies are required to pay benefits based upon benefit triggers called activities of daily living (ADLs). Policies must base benefits on at least six ADLs. They are:

- Bathing—Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence—The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
- Dressing—Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating—Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- Toileting—Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring—Moving into or out of a bed, chair, or wheelchair.

Some policies pay benefits based on seven ADLs.

Policies must pay benefits when you require assistance to perform three of the six activities of daily living or have a cognitive impairment. Many policies pay benefits when you are unable to perform two of the ADLs. A cognitive impairment is a deficiency in short-term or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness. Assessment of ADLs and cognitive impairment can be performed by licensed or certified professionals, such as physicians, nurses, or social workers. You would be considered unable to perform an activity of daily living if you need hands-on assistance to perform the activity or, in the case of a cognitive impairment, must have supervision or verbal cueing to protect yourself and others.

Preexisting Condition Waiting Period

If you are sick, or under a doctor's care for a particular condition when you purchase the policy, you may **not** be eligible for benefits for that condition until a certain period of time has passed. This is called a **preexisting condition waiting period**. Preexisting condition waiting periods vary from company to company. The longest waiting period permitted in Wisconsin is six months. This waiting period can be applied only to conditions that you have **not** been asked about on the application and for which you have seen or been treated by a doctor in the six months before you take out the policy.

Elimination Period

Policies frequently have elimination periods. This is the number of days you must be in a nursing home or other facility receiving the care covered by the policy or the number of home care visits that

must be received before benefits are paid. You will pay all of the cost of care during the elimination period. The longest elimination period permitted under Wisconsin law is 365 days. Usually, the longer the elimination period, the lower the premium. The longer the elimination period, the less chance there is that you will collect benefits. Elimination periods do not begin until the preexisting condition waiting period has been satisfied. Wisconsin law allows insurance companies to offer elimination periods up to 365 days, but the company must also sell the same type of policy that offers elimination periods for 180 days or less.

Inflation Protection

If your long-term care policy does not include a way for benefits to increase as long-term care costs increase, **you may have a benefit that is too low by the time you need care**. For example, a nursing home that costs $100 a day in 1995 could cost $150 or more in the year 2010. All policies must offer the option to purchase inflation protection at 5% compounded annually. Some policies may allow you to purchase additional coverage at a later date. Policies that express the maximum benefits as a dollar amount must also increase benefits at the rate of 5% compounded annually. Adding an inflation protection rider to a policy will increase the cost of the policy.

Waiver of Premium

Many policies provide for a waiver of premium. This means that after a specified period of time of **receiving** benefits under the policy you may apply to have your premiums waived until you are no longer receiving covered care or the lifetime maximum benefit has been paid.

Nonforfeiture Benefits

All policies must offer the option to purchase a shortened benefit period nonforfeiture benefit option. The nonforfeiture benefit provides paid-up long-term care, nursing home only, or home care only insurance coverage after you have paid premiums for three years but no longer continue to do so. The maximum benefit under the paid-up policy is the greater of 100% of the sum of all premiums paid for the policy, including premiums paid prior to any change in benefits, or 30 times the daily benefit amount in effect on the lapse date. As with the inflation protection option, a nonforfeiture benefit rider adds to the cost of the policy.

Long-Term Care Rate Increase Standards

If you have a policy that was issued between **August 1, 1996, and December 31, 2001**, your policy is subject to certain standards that restrict the number and amount of premium increases. Your initial premium may not increase for the first three years that the policy is in force, and after that the rate is guaranteed for at least two years. It is important for you to know that if the company raises premiums on its long-term care policy forms by more than 50% in any three-year period, it will be restricted from selling policies in Wisconsin. Although rate increases are applied to everyone having the same policy form, it is possible that categories of individuals covered under the policy form will see different amounts of increase based on the riders they purchased and the amount of risk associated with their age category. (Revised 04/2004)

There have been changes in Wisconsin insurance law that will provide added protection to you for those policies **issued on or after January 1, 2002**. The changes include rating practice and consumer protection provisions. Insurance companies will now be required to establish initial

premium rates that are sufficient and are expected to remain the same over the life of the policy. The insurance company will have to certify that no future premium increases are anticipated. Also, the insurance company is required to disclose to you your policy's past premium rate increases.

Contingent Nonforfeiture Benefit

Policies issued after January 1, 2002, must include a contingent benefit upon lapse requirement. The benefit will be triggered if your policy is subject to a substantial premium increase and you did not buy a shortened benefit nonforfeiture option. A contingent benefit upon lapse requirement will provide added protection to you in the event of lapse. For example, if you are 70 years old and you had rejected the insurance company's offer of a nonforfeiture benefit, and the premium rises to 40% more than the original premium you paid when you first bought the policy, you will be offered two options. The options will allow you to keep paying the original premium amount so you do not have to lapse the policy and lose your coverage. You will have the choice to reduce your benefit amount, or convert to paid-up status with a shorter benefit period. Of course, you may also choose to keep your policy and continue to pay the higher premium.

Policy Exclusions

Long-term care policies may have certain exclusions. The most common are for mental and nervous disorders, preexisting conditions, care received outside the USA, and care needed as a result of self-inflicted injury.

NOTE

Under Wisconsin law once you are insured and have satisfied any waiting periods, including elimination period, policies may not refuse benefits for irreversible dementia such as Alzheimer's disease, provided you need the services covered by the policy. Policies may exclude coverage for other conditions or situations. You should carefully review the Outline of Coverage that you receive when you are solicited for the policy. The Outline of Coverage will list the exclusions and summarize the type of coverage offered by the policy.

Renewability

All policies **currently on the market** are "guaranteed renewable for life." This means that your coverage will continue as long as you pay the premium. The renewal provision of a policy is on the first page of the policy and in the Outline of Coverage. The insurance company may raise premiums, but only if it raises them for all individuals who have the same policy. This does not mean that your coverage will continue if you have exhausted the benefits in the policy. If you buy a policy with a one-year benefit period, your benefits will end after one year of the insurance company paying benefits. You will not be able to renew these benefits.

Reinstatement

Policies also include reinstatement provisions. If you fail to pay premiums, the insurance company is required to give notice to you and your designee that the policy will lapse in 30 days. If your policy lapses and you provide proof of cognitive impairment or inability to perform activities of daily living, your policy can be reinstated if you request reinstatement within at least five months after lapse and pay the past due premiums.

Cost of Policy

The premium may vary according to many factors, including the policy benefits, your age, sex, and place of residence. The conditions under which the premium can be raised and the actual premium charged are discussed in the Outline of Coverage. Policies purchased at younger ages are generally less expensive than those bought at older ages.

Compare prices when you compare policies. Ask questions if the policy you are considering is a lot less or a lot more expensive than other policies with similar benefits.

Cancellation

You have the right to request cancellation of the policy at any time and the insurance company must issue a prorated premium refund. If you die while the policy is in force, the insurance company will issue a refund of premiums to your estate.

Health Questions

When you apply for long-term care insurance, you may be asked questions relating to your health status, including any prior hospitalization and nursing home confinements. Each insurance company has its own standards for deciding who is eligible for a policy. If the questions are not answered accurately, the insurance company may refuse to pay benefits, terminate the contract, and return your premium at the time you make a claim. Since the application is part of the policy, check it again when you receive the policy to make sure all questions have been answered accurately.

Using the Long-Term Care Insurance Checklist included in this guide will give you a more accurate idea of the actual policy premium.

Buying Tips

- Check on the agent selling the policy. You can check with the Office of the Commissioner of Insurance to see if an agent is licensed. It is a good idea to work with a local agent who will be available to help file claims and answer questions. Feel free to ask the agent how long he or she has been an agent, and the names of other companies the agent represents. Check with friends and neighbors for the name of a good agent and try to schedule an appointment in the agent's office.

- Try to compare several policies. A list of long-term care insurance policies currently being sold in Wisconsin is available from the Office of the Commissioner of Insurance.

- Call the **Medigap Helpline at 1-800-242-1060.** This is a nationwide toll-free number that has been set up by the state to answer questions for the elderly concerning health insurance.

- Check with the Office of the Commissioner of Insurance to find out whether there have been any administrative actions taken against the company or the agent.

Questions to Ask the Selling Agent:

- What type of policy is it, and what coverage does it provide? Is the policy considered a long-term care, nursing home only, or home health care only policy?

- What types of facilities or providers are eligible to provide the care covered by the policy? Are these facilities and providers available in my community?

- How long will the benefits last?

- How much will the policy pay each day?

- Does the policy have elimination periods before benefits begin? How long are they?

- Are there any preexisting condition limitations?

- What is the cost of nonforfeiture benefits? Inflation protection? Waiver of premium?

- What happens if you don't pay your premium?

- What conditions are not covered by the policy?

- What number of ADLs must be deficient?

- Is the policy considered a "tax-qualified" policy?

- Whom do you contact if you have questions about coverage or if you need help filing a claim?

Free-Look Periods

Policies must include a "free-look" period. You will have at least 30 days from the time you receive the policy to look it over and decide if you want to keep it. If you decide to return the policy to the company within the "free-look" period, you will receive a full refund of your premiums.

However, if you decide to keep the policy, be sure that your application is correct and complete. The application is a part of the policy.

Do not be misled by advertising.

Don't be misled by the endorsements of celebrities. Most of these people are professional actors who are paid to advertise insurance policies. They are not insurance experts.

Be wary of cards received in the mail that look as if they were sent by the federal government.

They may actually have been sent by insurance companies trying to find potential buyers. Be skeptical if you are asked questions over the phone about Medicare or your insurance. Any information you give may be sold to insurance agents who will call you or come to your home.

Don't overinsure.

It is not necessary to buy several policies. One good long-term care insurance policy, which covers both institutional and community-based care, is enough.

Be careful about dropping one policy to buy another.

Before you buy a new policy, be absolutely sure that it is better than the one you already have. Even if your agent has changed companies and wants you to change also, consider it carefully. If you do decide to switch policies, be sure that your new application is accepted before you cancel the old policy.

If you switch policies, you may be subject to new preexisting condition waiting periods or have other restrictions placed on your benefits. However, if you replace your policy and there is no lapse in coverage, the time you were covered under one policy counts toward meeting the preexisting condition waiting period under the new policy.

Never pay an agent in cash.

Pay by a check made payable to the insurance company.

Be sure to get the name, address, and telephone number of the agent and the company.

Obtain a local or toll-free number (if the company has one) so you can contact the company.

If you don't receive your policy within 45 to 60 days, contact the company or agent.

Glossary of Terms

Activities of Daily Living (ADLs)—Activities that are a normal part of everyday life, such as bathing, continence, dressing, eating, toileting, and transferring.

Adult Day Care—Care given in a nonresidential, community-based group program designed to meet the needs of functionally impaired adults. It is a structured, comprehensive program that may provide a variety of health, social, and related support services during any part of a day.

Alternative Plan of Care—If you otherwise qualify for benefits, this provision allows you to qualify for benefits not specifically listed in the policy upon the agreement of you, your physician, and the company.

Assisted Living Facility—A facility certified or registered by the Department of Health and Family Services (DHFS). These facilities exist to bridge the gap between independent living and nursing homes and provide a variety of services depending on the needs of the residents.

Bed Reservation—This benefit is payable if you are receiving nursing home care and need to spend time in a hospital. The company will cover any charge made by the nursing home for reserving your bed during your hospitalization.

Benefit Triggers—A term used to describe when to pay benefits. One type of benefit trigger is an activity of daily living (ADL). Insurance companies may use different events or types of benefit triggers to determine when benefits will begin to be paid. The triggers are described in the eligibility criteria of the policy.

Caregiver Training—Training provided in order to assist an informal and unpaid caregiver to care for you at home.

Care Coordination—Services provided by a licensed or certified health care professional designated by the insurance company to perform an assessment and develop a plan to meet your long-term care needs.

Case Management—Services provided by a licensed or certified health care professional to assist in arranging, monitoring, or coordinating long-term care services.

Cognitive Impairment—A deficiency in your short-term or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

Community Based Residential Facility (CBRF)—These facilities are licensed, registered, or certified by the Department of Health and Family Services (DHFS). CBRFs are covered only if your policy identifies these facilities as a covered benefit and the facility has been licensed as a CBRF by DHFS.

Contingent Nonforfeiture or Contingent Benefit Upon Lapse—If you reject the mandatory offer of a nonforfeiture benefit, the insurance company must provide a “contingent benefit upon lapse.” This means that when the premiums increase to a certain level (based on a table of

increase provided to you in the policy information), the benefit will take effect. You will then be offered, within 120 days of the due date of the new premium, the opportunity to accept **one** of the following options: 1) reduce your benefits provided by the current policy so that your premium will stay the same, or 2) convert your policy to a paid-up status with a shorter benefit period.

Elimination Period—The number of days you must wait after receiving long-term care before receiving insurance benefits.

Exclusion—Any condition or expense that the policy will not pay.

Guaranteed Purchase—A rider to a policy that allows you to increase the benefits during specific periods of time without proof of insurability.

Home Health Care—Care including skilled nursing services, such as providing therapy treatments or administering medication; home health aide services, such as checking temperature and blood pressure; personal care such as help with bathing, dressing, walking, exercise; and physical, occupational, respiratory, or speech therapy.

Hospice Care—A specially designed package of social and medical services that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families.

Instrumental Activities of Daily Living—Basic functional activities necessary for you to remain in your home, such as meal preparation, shopping, light housekeeping, laundry, telephoning, and handling money and paying bills.

Licensed Health Care Practitioner—Any physician, registered nurse, licensed or certified social worker, or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Paid-up Survivor—A rider that, in the event of the death of your spouse, waives the premiums for life if both you and your spouse had coverage for a specified time with the same company.

Plan of Care—A plan outlining the care you need and the length of time the care will be needed.

Residential Care Apartment Complexes (RCAC)—These facilities are certified by the Department of Health and Family Services (DHFS). RCACs are covered only if your policy identifies these facilities as a covered benefit and the facility has been certified as a RCAC by DHFS.

Respite Care—The provision of personal care, supervision, or other services to a functionally impaired person to relieve a family member or other primary caregiver from caregiving duties. Respite care services are usually provided in the impaired person's home or in another home or homelike setting, but may also be provided in a nursing home.

Restoration of Benefits—If you collect benefits from a policy and then recover to the point where you are not receiving care qualifying you for benefits for a certain period of time, you can have those benefits restored back to the original level. Look to see if this is a provision in the policy or if it is available as a rider for an additional premium.

Return of Premium—A rider that provides that if you die after being insured for a specified period or if you have paid premiums for a specified period, the insurance company will return premiums paid minus any benefits paid.

Waiver of Premium—The suspension of premium payments after you have been receiving benefits from the policy for the period of time specified in the policy.

What if I Have Questions or Complaints?

If you have questions or complaints about:

Medicare

Contact your local Social Security office or your county agency on aging, or you may contact the Social Security Administration by calling toll-free **1-800-772-1213**.

Medicaid

Contact the county Social Service Agency or the recipient hotline. In Madison the recipient hotline number is **(608) 266-4279.** In other parts of the state the number is **1-800-362-3002.**

Insurance

Contact the agent or company involved. If you do not get satisfactory answers, contact the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, Wisconsin, 53707-7873. Phone: **1-800-236-8517.** Deaf, hearing, or speech impaired callers may reach OCI through WI TRS**.**

OCI's World Wide Web Home Page

http://oci.wi.gov

LONG-TERM CARE INSURANCE CHECKLIST

Name and Address of Company:

Telephone Number:

Name and Address of Agent:

Telephone Number:

Type of Care Covered	Daily Benefit	Length of Benefit	Limitations
1. Institutional Care			
Nursing Home:			
Assisted Living Facility:			
Hospice Facility:			
Bed Reservation Guarantee:			
2. Community-Based Care			
Home Health Care:			
Adult Day Care:			
Respite Care:			
Hospice:			
Other:			

OTHER ITEMS

Elimination Period

Per occurrence:

Per Lifetime:

Waiting Period for Preexisting Conditions:

Premium Payment Period:

Attained Age (premiums increase as insured ages):

Issue Age (premiums will not increase merely due to increase in insured's age):

Lifetime or Period-Specific:

Policy Exclusions and Limitations:

Waiver of Premium:

Inflation Protection:

Nonforfeiture Benefits:

COST OF POLICY:

Basic Policy:

Inflation Protection:

Nonforfeiture Benefits:

Additional Benefits: